NOVEMBER 7, 2018

Mental Health Care Coordination

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REMOVING BARRIERS TO HEALTH CARE

A Responsible and Meaningful Approach…

The foundation of the proposed Mental Health Care Coordination program is based off of the following logic…

- There are known barriers to individuals with a mental health condition that prevent them from accessing routine and preventative health care.
- The lack of accessing preventative mental health care can lead to more costly health care in the future as crisis occurs.
- With this accepted logic we present a model based on promoting engagement with services to improve access and utilization of preventative health care.

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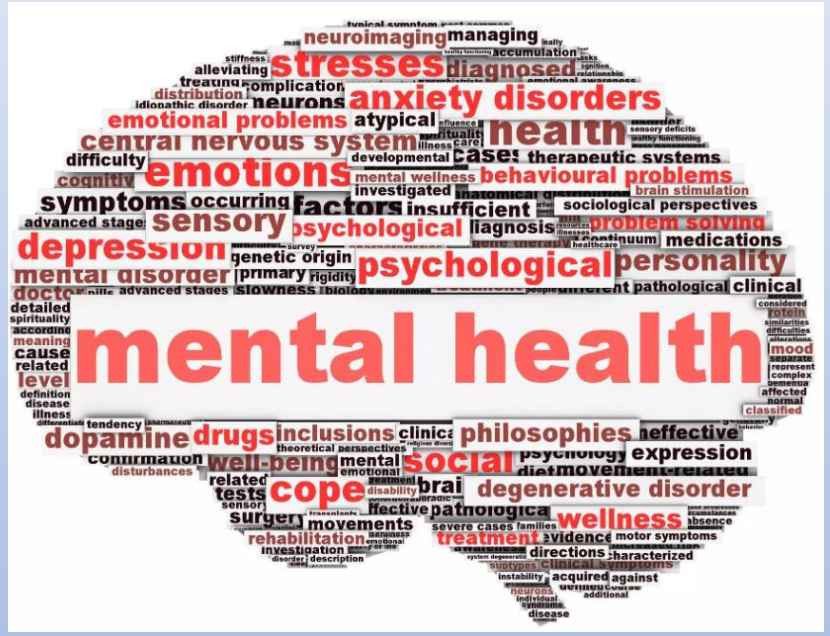
Introduction to the Mental Health Care Coordination Program

The keys to effective mental health treatment are...

1. **Access**
2. **Engagement**



Realities:

- According to John Hopkins Medicine, 1 in 4 people living in the United States have a mental health disorder. (John Hopkins Medicine 2016)
- Of those living with a mental health disorder, many live at or below the poverty line. (John Hopkins Medicine 2016)
- 15.4% of Montanans live below the poverty line. (Talk Poverty 2016)

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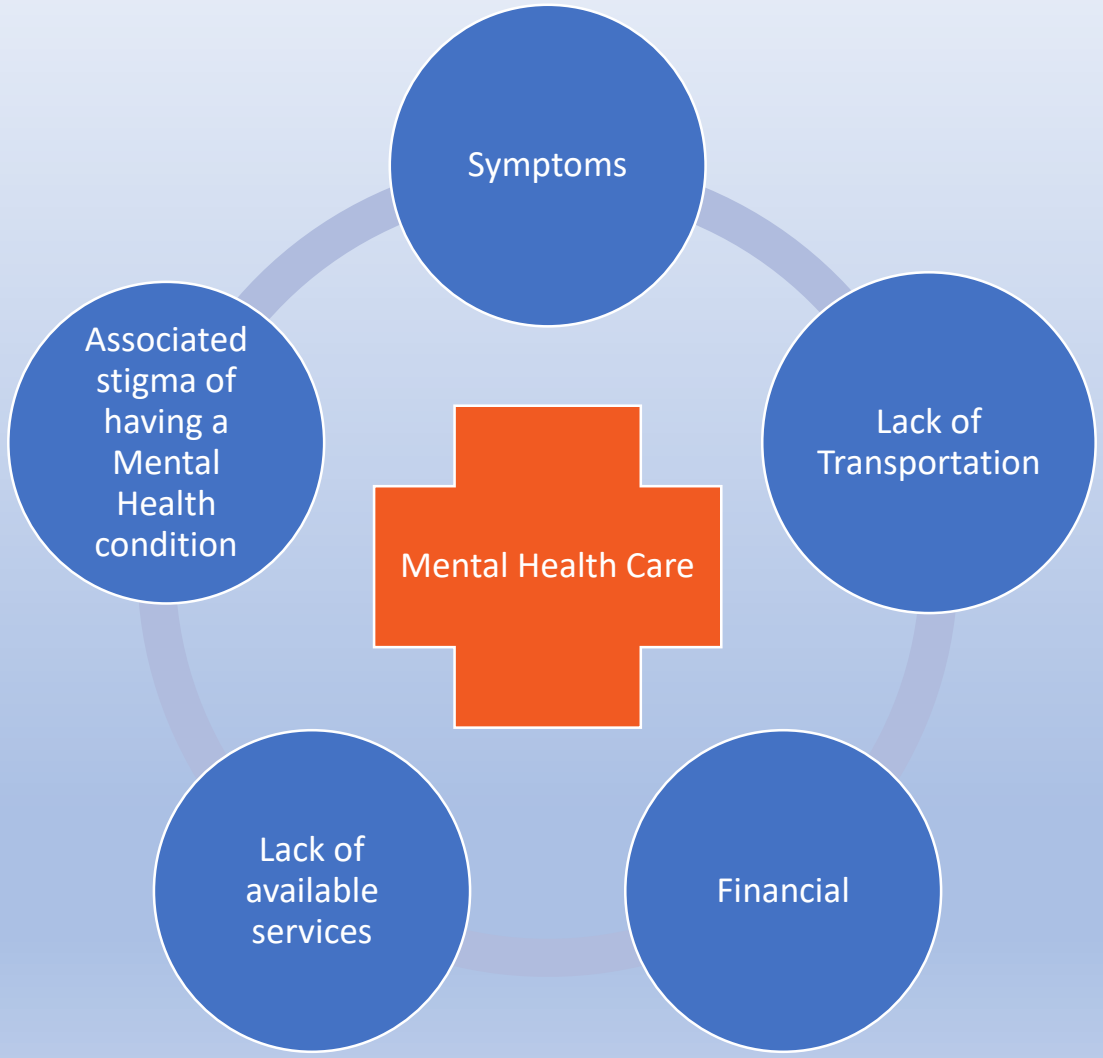
- Common Barriers to Mental Health Care



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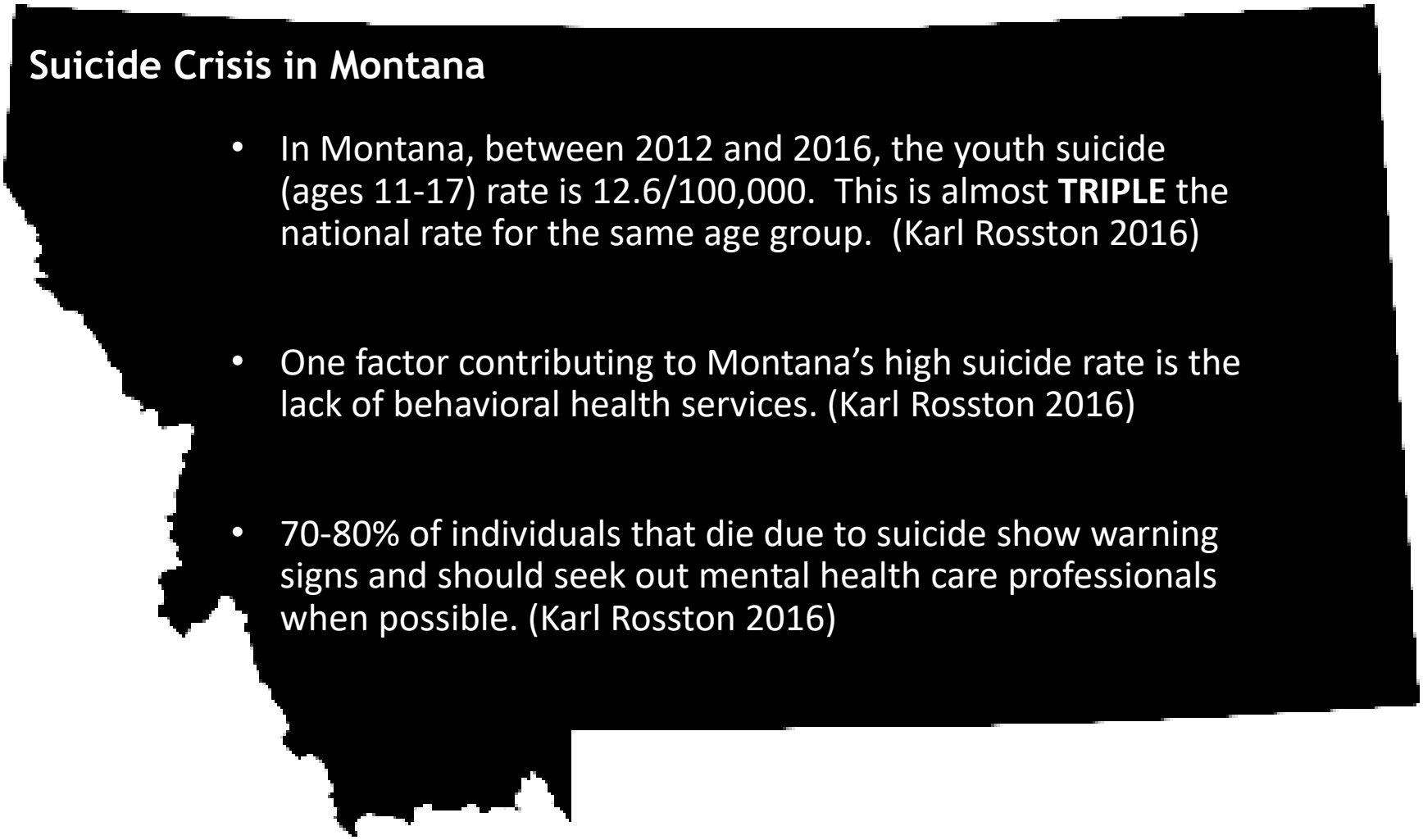

Suicide Crisis in Montana

- In Montana, between 2012 and 2016, the youth suicide (ages 11-17) rate is 12.6/100,000. This is almost **TRIPLE** the national rate for the same age group. (Karl Rosston 2016)
- One factor contributing to Montana's high suicide rate is the lack of behavioral health services. (Karl Rosston 2016)
- 70-80% of individuals that die due to suicide show warning signs and should seek out mental health care professionals when possible. (Karl Rosston 2016)

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Addressing the Suicide Crisis with Mental Health Care Coordination

According to the 2016 Montana BRFSS Annual Report:

Intentional Self-Harm caused 2.7% of the total deaths in Montana (267) and is linked to the following associated risk factors:

1. Depression
2. Alcohol or substance abuse
3. Major stressor events

This same population age average (25.9) is also the same range of Montana's reported to have frequent poor mental health and no routine health checkup in the past year.

Mental Health Care Coordination:

1. Promotes routine health care appointments
2. Coordinates appropriate mental health services to address depression
3. Facilitates involvement with drug and alcohol programs
4. Supports an individual to further develop their circle of support to help lessen the impacts of stressful life events.

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Program Objective:

To promote service engagement that encourages and promotes individual's independence for adults and children living with a mental illness.

Population Focus:

Mental Health Care Coordination Services will be provided to both children and adults who have a qualifying Medicaid mental health diagnosis. Individuals participating are those who require supports beyond traditional outpatient therapy setting including those who are at risk of being placed in a facility other than the home, loss of employment, low school attendance, and legal/court involvement.

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Description of Program:

This model of Care Coordination provides referral/follow-up and monitoring for participants who are **accessing at least 2 care systems**, which includes but is not limited to: mental health, educational, law enforcement, medical, employment, housing, transportation, etc. Given the remote and rural nature of Montana, this model supports an open enrollment care coordination system that allows for **flexibility** in service delivery to foster independence and meet the individual's needs. A major focus is placed on **linkages to needed community services** and the ultimate fading of care coordination interventions while simultaneously increasing independence and non-paid natural and community supports.

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Description of Program:

Community care services include those which promote health and well-being and aims to reduce the need for paid professional supports. Participants will be supported in engaging in these community care services and guided by the care **coordination service plan**, which is created in conjunction with the individual and their team to promote individual responsibility. Outcomes will be measured through engagement and individualized goals as designated in the care coordination service plan.

This focus will encompass all aspects of the individual's life/needs and place **the measurement of a quality** and meaningful care coordination program in the ability of the care coordinator to engage the individual in service participation.

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Required Care/Care Coordination Staff:

This program would employ and train bachelors (or equivalent) level care coordinators who demonstrate the following skill set:

- **time management**
- **relationship building**
- **effective written and verbal communication**
- **meeting facilitation**
- **culturally competent**
- **professionally empathetic**

The care coordinator position would not require clinical oversight but would be supervised by an experienced bachelors level manager.

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Program Demographics:

- **Average # of Members per Provider:** 25 individuals served per care coordinator
- Cite studies on caseload size

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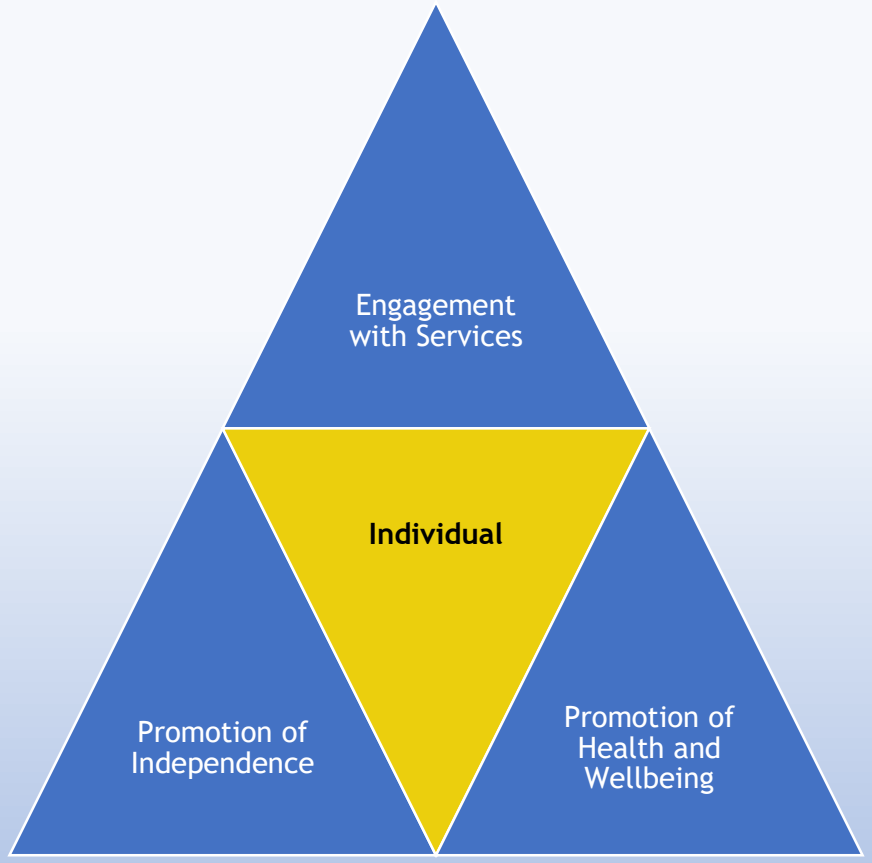
Program Outcomes and Measurement:

The program is measured based on the outcomes of individuals' service plan goals. Overall program success is measured by assessing individuals' progress in the below listed core areas. Agencies will collect baseline scores in the first year. Following year one, DPHHS will set thresholds for agencies using baseline data reported.



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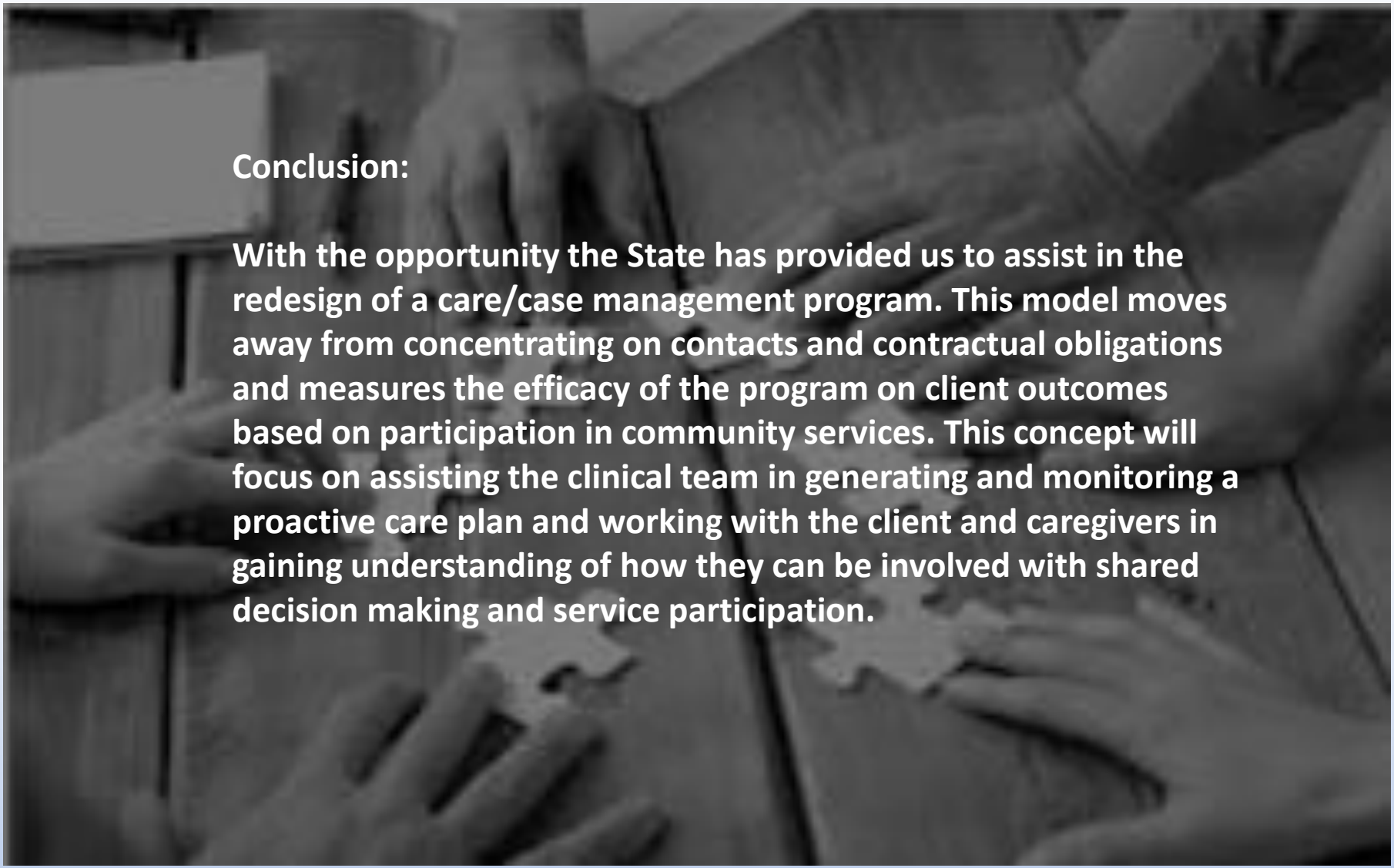

Conclusion:

With the opportunity the State has provided us to assist in the redesign of a care/case management program. This model moves away from concentrating on contacts and contractual obligations and measures the efficacy of the program on client outcomes based on participation in community services. This concept will focus on assisting the clinical team in generating and monitoring a proactive care plan and working with the client and caregivers in gaining understanding of how they can be involved with shared decision making and service participation.

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References

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